| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '  | E CONSTRUCTION            | (X3) DATE  |           |                          |
|---|--|--|---------------------------|--|-----------|--------------------------|
| AND FLAN  | OF CONNECTION  | IDENTIFICATION NOMBER.   | A. BUILDING: <b>01</b>    |  | COMPLETED |                          |
|   |  | HAL025026  | B. WING                   |  | 01/2      | ₹<br>1/2016              |
| NAME OF F   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE  |           |                          |
| RIVERST   | ONE  |  | D BOULEVAI<br>RN, NC 2856 |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| {C 000}   | Initial Comments   |  | {C 000}                   |  |           |                          |
|   | Report of Follow-up Survey by Frank Strickland and Billy Bryant on 01/21/2016:   |  |                           |  |           |                          |
|   | Some cited deficiencies have been field verified for correction. However, a majority of the cited deficiencies have not been corrected and require corrective action. A new Plan of Correction is required.  |  |                           |  |           |                          |
| {C 164}   | {C 164} Housekeeping and Furnishings-Clean, Repaired   |  | {C 164}                   |  |           |                          |
|   | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. |  |                           |  |           |                          |
|   |  | et as evidenced by: vations, the facility has failed to clean and in good repair.  |                           |  |           |                          |
|   | build-up around the meet the walls at the doorways. b- There is a large a Activity Room. c- The floor tiles in cracked, and discolu  | facility, there is wax/ dirt a door frames, where the floors be vinyl base, and in the area of stained floor tiles in the the Beauty Shop are broken, lored. the fire doors (both halls) are |                           |  |           |                          |
|   | 2- Based on observ   | vations, the facility has failed to  |                           |  |           |                          |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMEN                 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|----------------------------|---|-------------------------------|--------------------------|
| "'                       |  |   | A. BUILDING: <b>01</b>     |   | R                             |                          |
|                          | HAL025026  |   | B. WING                    |   | 01/21/2016                    |                          |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S             | STATE, ZIP CODE   |                               |                          |
| RIVERS1                  | ONE  |   | D BOULEVAI<br>N, NC 2856   |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| {C 164}                  | Continued From pa  | ge 1  | {C 164}                    |   |                               |                          |
|                          | maintain the walls of  | lean and in good repair.  |                            |   |                               |                          |
|                          | Findings include:  |   |                            |   |                               |                          |
|                          | a- In the Beauty Shop, one of the walls is dirty or stained. b- There is a pattern of torn or ragged wallcovering throughout the facility. Specific examples include but are not limited to: 1- Shower Room 6. 2- Resident Room 129 3- Resident Room 126 c- The walls in the bathroom of Resident Room 110 are damaged and in need of repair. d- One of the walls in the bathroom of Resident Room 103 has a hole in it. e- The wall located at the bed in Resident Room 127 is spattered and badly stained. f- The grout in the tile of Shower Room 2 is dirty and appears to be growing mildew. g- The grout is missing in the shower of Bathing Room 1.  3- Based on observations, the facility has failed to maintain the facility 's furniture in a clean and |   |                            |   |                               |                          |
|                          | Findings include:  |   |                            |   |                               |                          |
|                          | and in bad repair.<br>b- The box springs   | Resident Room 115 is torn and bed in Resident Room the mattress is in bad repair. |                            |   |                               |                          |
| {C 166}                  | Housekeeping-Mair  | ntained Free of Hazards   | {C 166}                    |   |                               |                          |
|                          | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS   |   |                            |   |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 4LV022 If continuation sheet 2 of 7

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING: | PLE CONSTRUCTION (X3) DATE : G: 01 COMPL   |      |                          |
|---|--|---|------------------------------|--|------|--------------------------|
|   |  |   |                              |  | R    |                          |
|   |  | HAL025026   | B. WING                      |  | 01/2 | 1/2016                   |
| NAME OF   | PROVIDER OR SUPPLIER   |   |                              | STATE, ZIP CODE  |      |                          |
| RIVERS  | TONE   |   | D BOULEVAI<br>NN, NC 2856    |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| {C 166}   | orderly manner, fre hazards; (e) This Rule shall facilities.  This Rule is not me 1- Based on observice the building almaintained.  Findings include:  a- In the kitchen, the that is severely rust c- In the Staff Breat moulding has splint exposed.   | es shall: in an uncluttered, clean and e of all obstructions and apply to new and existing et as evidenced by: vation, the facility has failed to nd its environment clean and ere is a metal shelving unit         | {C 166}                      |  |      |                          |
|   | maintain the building Findings include:  a- In Room 127, the is falling off the hing b- In Shower Room commode is loose a c- The exterior light 116 is not working. d- In the Resident Countries an electrical equipped with overleter are items electrical panel in the f- In the Corridor, the standard of the contribution of the corridor, the standard of the corridor, the corridor, the corridor, the corridor, the corridor, the corridor of the corri | e door on an overhead cabinet ges.  1, the grab bar beside the at the wall.  at the EXIT door near Room  Care Coordinator 's office, al extension device that is not load protection.  being stored in front of the |                              |  |      |                          |

Division of Health Service Regulation

STATE FORM 6899 4LV022 If continuation sheet 3 of 7

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>   |                          | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|---|---|--|--------------------------|--|------------|--------------------------|
|   |   |  | A. BOILDING. VI          |  | R          |                          |
|   |   | HAL025026  | B. WING                  |  | 01/21/2016 |                          |
| NAME OF F   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S           | STATE, ZIP CODE  |            |                          |
| RIVERST   | ONE   |  | D BOULEVAI<br>N, NC 2856 |  |            |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE A | D BE       | (X5)<br>COMPLETE<br>DATE |
| {C 166}   | Continued From pa   | ge 3   | {C 166}                  |  |            |                          |
|   | following areas that<br>containers or in cor<br>proper support to pr<br>Locations to include<br>3- Oxygen Stor  | n bottles located in the are either not stored in tainers that do not provide revent them from falling over. |                          |  |            |                          |
| {C 189}   | Building Equipment  | Maintained Safe, Operating   | {C 189}                  |  |            |                          |
|   | SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. |  |                          |  |            |                          |
|   | not maintained safe<br>deficiencies may af<br>who may have to us  | ations, plumbing systems are and operating. These fect residents, staff, or visitors se these facilities.    |                          |  |            |                          |
|   | Findings on include   | :  |                          |  |            |                          |
|   | functioning, has no<br>is not equipped with<br>b- The commode in<br>Sanitation is soiled<br>c- The commodes i   | the Toilet Room beside the   |                          |  |            |                          |

Division of Health Service Regulation

STATE FORM 6899 4LV022 If continuation sheet 4 of 7

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b> |  | (X3) DATE SURVEY<br>COMPLETED |                  |
|--------------------------|--|--|--|--|-------------------------------|------------------|
|                          |  |  |  |  | R                             |                  |
|                          |  | HAL025026  | B. WING  |  | 01/2                          | 1/2016           |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |  | STATE, ZIP CODE  |                               |                  |
| RIVERS1                  | ONE  |  | D BOULEVAI<br>RN, NC 2856                          |  |                               |                  |
| (X4) ID                  | SLIMMARY STA   | TEMENT OF DEFICIENCIES   | ID   | PROVIDER'S PLAN OF CORRECTION  | ON                            | (X5)             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                                      | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | COMPLETE<br>DATE |
| {C 189}                  | Continued From pa  | ge 4   | {C 189}  |  |                               |                  |
|                          | are not limited to:  1- Resident Ro 2- Shower Roo d- The water cooler machines does not  2- Based on observ not maintained safe deficiencies may af who may work, occ  Findings include:  a- The ceiling mour the Laundry has no b- In the 100 Hall M were noted. To inclu 2- The wall | m 3 I located beside the drink work  vations, electrical systems are e and operating. These fect residents, staff, or visitors upy, or visit the facility.  Inted fluorescent light fixture in |  |  |                               |                  |
|                          | has no cover.  | e ceiling mounted light fixture vations, fire safety systems are   |  |  |                               |                  |
|                          | not maintained safe and operating. These deficiencies may affect residents, staff, or visitors who live, work, or visit the facility.  |  |  |  |                               |                  |
|                          | Findings include:  |  |  |  |                               |                  |
|                          | areas do not work of include but are not 1- Activity Room 2- Living Room b- The screws are pon the Central Hall difficult to open in the   | oulling out of the door/closer<br>EXIT door, making the door<br>ne event of an emergency.  |  |  |                               |                  |
|                          | 4- Based on observations, the facility failed to   |  |  |  |                               |                  |

6899

Division of Health Service Regulation STATE FORM

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b> |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|--|--|-------------------------------|--------------------------|
|                          |   |  | 7. BOLDING. 01                                     |  | R                             |                          |
|                          |   | HAL025026  | B. WING  |  | 01/2                          | 1/2016                   |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |  | STATE, ZIP CODE  |                               |                          |
| RIVERS1                  | TONE  |  | D BOULEVAI<br>N, NC 2856                           |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| {C 189}                  | Continued From pa   | ge 5   | {C 189}  |  |                               |                          |
|                          | the fire resistance of deficiency directly a and visitors by allow smoke beyond the Findings on include a- There are unprof following locations of 3- There is a la ceiling of Room b- The corridor doo   | rected penetrations in the to include but not limited to: rge, open crack in the   |  |  |                               |                          |
| {C 199}                  |   | the fire-resistant rating of the   | {C 199}  |  |                               |                          |
|                          | provided with exhautwo cubic feet per na requirement does in before April 1, 1984 these specified spa (1) soiled linen stor (2) soil utility room; (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app | ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This not apply to facilities licensed with natural ventilation in ces: rage; toilet rooms; closets; and apply to new and existing ception of Paragraph (e) ly to existing facilities. |  |  |                               |                          |

Division of Health Service Regulation

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                           | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  01   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|------------------------------|--|-------------------|--------------------------|
|                          |  |  | D. WING                      |  | R                 |                          |
|                          |  | HAL025026  | <u>l</u>                     |  | 01/2              | 1/2016                   |
|                          | PROVIDER OR SUPPLIER                       |  | DRESS, CITY, S<br>D BOULEVA  | STATE, ZIP CODE<br><b>RD</b>   |                   |                          |
| RIVERS                   | TONE                                       |  | RN, NC 2856                  |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                           | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| {C 199}                  | Continued From pa                          | ge 6   | {C 199}                      |  |                   |                          |
|                          | has failed to mainta<br>systems in working | in the mechanical exhaust condition.   |                              |  |                   |                          |
|                          | Findings include:                          |  |                              |  |                   |                          |
|                          | completely clogged b- There are cleaning   | ng chemicals being stored in however there is no                             |                              |  |                   |                          |
|                          |  |  |                              |  |                   |                          |

6899

Division of Health Service Regulation STATE FORM